SECTIONS 2 , 3 and 4

Utah Home And Community-Based Waiver Services For Individuals With Acquired Brain Injury Age 18 And Older

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1 GENERAL POLICY

Under Section 1915(c) of the Social Security Act, a State may request approval through the federal Health Care Financing Administration (HCFA) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. Since July 1, 1996, the State of Utah has provided Medicaid-reimbursed home and community-based waiver services for individuals with acquired brain injury age 18 and older. The approval includes waivers of:

- the "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act, and
- the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide the services described in Chapter 3, *Home and Community-Based Waiver Services,* of this manual to *only a limited number* of eligible individuals who meet the State's criteria for Medicaid reimbursement in a nursing facility (NF). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-effective"alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements, the State uses more liberal eligibility and post-eligibility income and resource calculations when determining recipients' Medicaid eligibility. For example, recipients are permitted to retain more of their monthly income than NF recipients in order to compensate for the higher costs associated with living in the community.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for individuals with brain injury age 18 and older, the following acronyms and definitions apply:

Acquired Brain Injury Is injury related and neurological in nature. This would not include those whose primary diagnoses are substance abuse, or those with deteriorating diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer, but would include cerebral vascular accident.

DSPD Division of Services for People with Disabilities

DHCF Division of Health Care Financing

HCFA Health Care Financing Administration

HCBS Home and Community-Based Services

NF Nursing facility

1 - 2 Qualified Providers

A. Home and community-based waiver services for recipients with acquired brain injury are covered benefits only when delivered by or through providers who are under contract with the Division of Services for People with Disabilities (DSPD) and who are enrolled with the Medicaid agency to provide such services.

B. Agencies and individuals providing home and community-based waiver services must meet the applicable licensure, certification, and other standards as described in the approved waiver.

C. Application for license must be made to the Utah Department of Human Services, Office of Licensure.

D. Application for certification must be made to the Utah Department of Human Services, Division of Services for People with Disabilities.

1 - 3 Service Standards

In addition to service standards and limitations described in this manual, home and community-based waiver providers will be held accountable to the standards and policies contained in:

A. Their provider contracts with the Division of Services for People with Disabilities, Utah Department of Human Services;

B. The *Policy Manual of the Division of Services for People with Disabilities* (as applicable to the acquired brain injury waiver); and

C. The Medicaid *Provider Agreement for Title XIX Home and Community-Based Services Waiver for Individuals with Acquired Brain Injury* filed with the Utah Department of Health, Division of Health Care Financing.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided:

A. to an eligible recipient residing in the community in Utah;

B. by or through a qualified, enrolled Medicaid provider (as described in Chapter 1 - 2, *Qualified Providers*); and

C. pursuant to a written plan of care.

2 - 1 Eligibility for Waiver Program

A. Home and community-based waiver services are covered benefits only *for a limited number of Medicaid eligibles* who, but for the provision of such services, would require the level of care provided in a Medicaid-certified NF, the cost of which would be reimbursed under the Medicaid State Plan.

B. Only a qualified waiver support coordinator may determine (and periodically redetermine) an applicant's eligibility for home and community-based waiver services.

C. Once determined eligible, each individual must be offered choice of receiving either NF or home and community-based waiver services.

D. Inpatients of hospitals, nursing facilities, or ICFs/MR are not eligible to receive home and community-based waiver services (except as specifically permitted for case management discharge planning under Chapter 3 - 1 (*Case Management,* item D).

2 - 2 Access to Services

The Division of Services for People with Disabilities (DSPD) is the only enrolled provider of waiver support coordination services for this waiver and is the first point of contact for access to waiver services. Prior to admitting an individual to the acquired brain injury waiver, a DSPD-qualified waiver support coordinator must do all of the following:

A. Obtain required and other necessary evaluations and thoroughly assess the individual's needs and condition;

B. Determine whether the individual qualifies for Medicaid-reimbursed NF care and services;

C. Determine whether feasible alternatives are available in the community, including waiver services;

D. Ensure the individual is Medicaid eligible;

E. Offer the eligible individual an informed choice of waiver services or NF services; and

F. Certify on DSPD Form 817b that the individual meets the criteria for and chooses to receive home and community-based waiver services.

2 - 3 Assessment

An assessment provides information for the qualified waiver support coordinator to determine whether waiver services constitute an acceptable alternative to NF care and, if so, which waiver and other services are needed to maintain the individual in the community. The waiver support coordinator consults with physicians and other health professionals as necessary to thoroughly evaluate an individual's clinical condition. Through the assessment process, a support coordinator obtains the required diagnostic documentation from a physician.

A waiver support coordinator reviews the required and other necessary documentation to ascertain the individual's health, medical, social, neurological, psychiatric, and functioning levels. Only after such a review, will the support coordinator be presumed to have sufficient information to determine whether an individual's condition and needs meet the level-of-care criteria.

2 - 4 Level-of-Care Evaluation ("Waiver Certification")

Level-of-care evaluations (and periodic reevaluations) are conducted by and through waiver support coordinators.

A. The support coordinator will certify that an individual meets the acquired brain injury waiver level-of-care requirements only when the individual meets the following conditions:

1. Requires care above level of room and board as documented by at least two of the following criteria:

   a. Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

   b. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires NF care; or

   c. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less-structured setting and alternatives have been explored and are not feasible.

2. **Plus** must meet all of the following:

   a. Primary condition is not attributable to mental illness;

   b. Cannot be maintained in a less restrictive environment without Acquired Brain Injury waiver services;

   c. Documentation of a Brain Injury with a **score between 40 - 120** on the Brain Injury Waiver Comprehensive Assessment Form (Intake, Screening, and Assessment Form–Part II).

B. Eligible individual's level of care is certified by the support coordinator on DSPD Form 817b.

2 - 5 Required Documentation for Level-of-Care Evaluation

At a minimum, the following documentation must be obtained and included in an individual's or recipient's file to support a waiver level-of-care determination.

A. Documentation of brain injury signed by a licensed physician;

B. A Brain Injury Waiver Comprehensive Assessment, completed within the last year by a qualified professional. To be eligible for services, the individual's degree of functioning must be rated at a level between 40 and 120 on the comprehensive assessment. The scale must be readministered if the individual's current level of functioning is inconsistent with the documentation on the most recently administered scale. (A qualified support coordinator under contract or employment with DSPD, or someone with at least a bachelor's degree in a field related to human services is qualified to administer the scale.);

C. The Comprehensive Assessment form, indicating a total score not less than 40 nor more than 120. If the total score from the Comprehensive Assessment form is 120 or higher or 40 or lower, the individual is ineligible;

D. Social History Summary, Form 824, completed or updated within one year prior to eligibility; and

E. An 817b form, Home and Community-Based Services Waiver Level-of-Care Determination-Brain Injury--completed and signed by a qualified support coordinator.

2 - 6 Recipient Freedom of Choice

A. When an individual is initially determined eligible for waiver services, the individual or legal representative will be informed of the alternatives available under the waiver. If there is a waiting list for admission to the waiver, the waiver support coordinator will inform the individual about DSPD's waiting list procedures and selection criteria. Refer to Chapter 2 - 7, *Waiting List*.

B. Once informed of the feasible alternatives under the waiver, the eligible individual or legal representative will be offered the choice of institutional (NF) or home and community-based services. The individual's choice is documented on DSPD Form 817b.

C. An individual will not be offered waiver services if the assessment indicates he or she cannot be adequately served in the community.

D. The waiver support coordinator will offer the choice of waiver services only when two conditions are met:

1. The individual's needs can be met appropriately in the community with waiver services;

2. All parties have agreed to the plan of care. Refer to Chapter 2 - 8, *Plan of Care*.

If waiver services are chosen, the individual or legal representative will also be given the opportunity to choose the providers of waivered services if more than one qualified provider is available. The individual's choices of services and providers are documented in the plan of care.

E. Once the individual has chosen home and community-based waiver services and the choice has been documented by the waiver support coordinator, annual re-documentation of choice is not required. However, a recipient has the option to choose institutional (NF) care at any time he or she is receiving waiver services.

2 - 7 Waiting List

In accordance with Utah's approved brain injury waiver, the State may serve only a limited number of recipients during each waiver year. For purposes of this waiver, a "waiver year" is the State of Utah fiscal year (July 1 of one year through June 30 of the following year).

When the number of recipients served during the waiver year reaches the number approved by HCFA, a waiting list will be established. When vacancies occur, the Regional DSPD office(s) will, in accordance with waiting list policy and procedures, determine the next enrollee in the waiver program.

2 - 8 Plan of Care

The plan of care is the fundamental tool by which the State ensures the health and safety of recipients. The plan of care constitutes a plan for services, supports, and life activities determined necessary to meet the needs of the individual or recipient and to prevent institutionalization. It describes all of the services the recipient needs, including waiver services and non-waiver services.

A. Prior to the delivery of waiver services, there must be a completed plan of care. The plan of care must include the following elements:

- Effective date;
- Name of recipient;
- Address;
- Support coordinator's name and office location;
- All services needed by the recipient, regardless of funding source, including support coordination in all cases;
- Documentation that recipient was advised of hearing rights, if not provided choice;
- Documentation that individual was informed of his or her rights in accordance with DSPD policies per R539-2-1 and R539-2-5 and rights to hearing;
- Expected start date, amount, frequency, and duration of each service;
- The type of provider who will furnish each service;
- Habilitation/rehabilitation goal for each service, where appropriate;
- Signatures of recipient, support coordinator, and legal representative (when applicable) and date signed.

B. The plan of care is developed by the waiver support coordinator in consultation with the individual and/or legal representative, or others as necessary and appropriate.

C. The waiver support coordinator is responsible for ensuring the recipient receives the services identified in the plan of care.

2 - 9 Periodic Review of the Plan of Care

A. The waiver support coordinator is responsible for ensuring that the plan of care is reviewed and updated as necessary to:

1. note the recipient's progress (or lack of progress);

2. determine the continued appropriateness and adequacy of the recipient's services; and

3. ensure that the services identified in the plan of care are in fact being delivered and are consistent with the nature and severity of the recipient's disability.

B. The plan of care is updated or revised as necessary by the waiver support coordinator in consultation with the recipient and/or legal representative, and others as appropriate. A formal review of the plan of care must be completed at least every 12 months within the calendar month in which it is due.

2 - 10 Periodic Review of the Level of Care ("Waiver Recertification")

A. The waiver support coordinator must complete the level-of-care evaluation at least annually within 12 months after entry into the waiver for the brain injured or within 12 months of the most current assessment with completion during the calendar month in which it is due. The purpose of the reassessment is to document the recipient's level of care and to assure that waiver services continue to be a feasible alternative to institutionalization for the recipient and adequately meet the recipient's needs.

B. Reevaluations must be conducted as follows:

1. A comprehensive reassessment of the recipient by the waiver support coordinator must be conducted in order to determine if the recipient continues to be eligible for the home and community-based waiver for the brain injured.

2. The waiver support coordinator is responsible for recertifying the need for continued service. The initial level-of-care determination must be reevaluated along with the Brain Injury Waiver Comprehensive Assessment Form, and social and behavioral history to determine if services are still necessary and appropriate. Changes since the initial evaluation must be documented; or if no change has occurred, there must be documentation why an update is not needed.

C. The waiver support coordinator documents the level-of-care recertification on Form 817b.

D. Recipients found ineligible for continued waiver services will receive notice and hearing rights in accordance with Chapter 2 - 12, *Fair Hearings.*

2 - 11 Termination or Reduction of Home and Community-Based Waiver Services

The waiver support coordinator will provide a written notice to a recipient and/or his or her legal representative upon termination or reduction of home and community-based waiver services. The recipient and/or legal representative will also receive a notice of the right to appeal such decisions.

A. Waiver services may be terminated or reduced for the following reasons:

1. Death of the recipient;
2. Whereabouts of the recipient unknown;
3. Recipient no longer meets the level-of-care requirements;
4. Recipient moved out of the state of Utah;
5. Recipient voluntarily withdrew from the waiver program;
6. Waiver services are no longer a feasible option;
7. Recipient is no longer eligible for Medicaid;
8. A change in health or functional status of the recipient; or
9. Recipient was placed in an institution.

2 - 12 Fair Hearings

A. The Utah Department of Health will provide an opportunity for a fair hearing to recipients for any of the following reasons:

1. Denied eligibility for waiver services;

2. Determined eligible for waiver services but not offered the choice of home and community-based services as an alternative to NF services; or

3. Denied access to an available service or provider of their choice.

B. Agency Responsibility for Fair Hearings

1. Department of Human Services, Division of Services for People with Disabilities:

a. An individual or recipient will receive written Notice of Decision (Utah Department of Human Services Form 522) from the waiver support coordinator if he or she is found ineligible for, denied access to, or experiences a reduction in waiver services.

b. The notice will inform the individual/recipient of his or her right to request a hearing in accordance with the Department of Human Services administrative hearing procedures. Requests for hearings (Form 490) are sent to the Department of Human Services, Office of Administrative Hearings, and that office is responsible for notifying the Department of Health, Division of Health Care Financing (the Medicaid agency).

2. Department of Health, Division of Health Care Financing:

a. The Department of Health will provide an opportunity for a fair hearing to home and community-based recipients who are:

(1) not offered the choice of institutional (NF) services or community-based waiver services;

(2) eligible for but are denied the waiver services of their choice; or

(3) denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

b. It is the policy and preference of the Division of Health Care Financing to resolve disputes at the lowest level through open discussion and negotiation between the Division, individuals/recipients, and all other interested parties.

C. The Utah Department of Health provides hearing rights to providers who believe they have been aggrieved by the Utah Department of Health, Division of Health Care Financing, and who submit a written request for a hearing to the agency. Please refer to the Utah Medicaid Provider Manual, SECTION 1, Chapter 6 -14, *Administrative Review/Fair Hearing,* for procedures.

3 HOME AND COMMUNITY-BASED WAIVER SERVICES

Home and community-based waiver recipients are eligible to receive regular Medicaid State Plan benefits (i.e., hospital, physician, pharmacy, medical equipment and supplies). In addition, **when necessary to prevent institutionalization and delivered pursuant to a written, signed plan of care, the waiver services listed below are available to recipients:**

- Support Coordination
- Homemaker
- Respite Care
- Supported Employment Services
- Specialized Medical Equipment and Supplies
- Personal Emergency Response Systems
- Companion Services
- Family Training
- Structured Day Program
- Community Supported Living
- Counseling
- Transportation

3 - 1 Support Coordination

A. Support Coordination services assist recipients to gain access to and coordinate needed assessment, medical, social, education, and other services, regardless of the funding source for the services to which access gained.

B. Medicaid reimbursement for support coordination is dictated by the nature of the activity and the purpose for which the activity was performed. Time spent by a waiver support coordinator performing covered activities will be reimbursed on a 15-minute unit basis.

C. When delivered by a qualified individual and billed in reasonable amounts (given the documented needs and condition of the particular client), the following activities and services are covered by Medicaid under support coordination:

1. Assessing and documenting the recipient's need for community resources and services including time spent developing the recipient's social history and initiating, coordinating, and overseeing the process of evaluating the recipient's level of care;

2. Developing, documenting, implementing, and coordinating the recipient's plan of care to ensure he or she gains access to needed services; updating and modifying the plan of care as necessary and required;

3. Linking the recipient with needed community resources including assisting the recipient to establish and maintain eligibility for entitlements **other than Medicaid;**

4. Coordinating the delivery of services to the recipient by encouraging the use of cost-effective medical care, and discouraging overutilization of costly and unnecessary services (such as emergency room care for routine procedures);

5. Monitoring the provision of services included in the recipient's plan of care to ensure the continued availability and quality of delivered services;

6. Instructing the recipient or caretaker, as appropriate, in independently obtaining access to needed services for the recipient; and

7. Assessing periodically the recipient's progress and reassessing his or her continued need and eligibility for waiver services.

D. The waiver support coordinator will bill Medicaid for the above activities **only if:**

1. The activities are delineated in the recipient's plan of care; and

2. The time spent in the activity involved a face-to-face encounter, telephone or written communication with the recipient, family or legal representative, caretaker, service provider, or other individual directly involved in providing or assuring the recipient obtained a service documented in the plan of care.

E. In accordance with federal Medicaid guidelines, the following are **not** considered waiver support coordination services and should **not** be billed to Medicaid as such:

1. Documenting support coordination services (with the exception of time spent documenting initial and periodic level-of-care assessments, plans of care, and quarterly progress notes);

2. Teaching, tutoring, training, instructing, or educating the recipient or others, except insofar as the activity is specifically designed to assist the recipient, parent or legal representative, or caretaker to independently obtain needed services for the recipient. For example, assisting the recipient to complete a homework assignment or instructing his or her family members on nutrition, budgeting, cooking, parenting or other skills development;

3. Directly assisting with personal care or activities of daily living. For example, assisting with budgeting, cooking, shopping, laundry, apartment hunting, moving residences, or acting as a protective payee;

4. Performing routine services, including courier services. For example, time spent running errands or picking up and delivering Food Stamps or entitlement checks;

5. Providing direct medical or remedial services other than support coordination. For example, conducting psychological evaluations or providing treatment, therapy and counseling (although these may be billable to Medicaid under other categories of service);

6. Traveling to the recipient's home or other location where a covered support coordination activity will occur, nor is time spent transporting a recipient or a recipient's family member;

7. Providing services for or on behalf of other family members which do not directly assist the recipient to gain access to needed services. For example, counseling the recipient's sibling or evaluating the recipient's parents' need for services;

8. Time spent performing activities necessary for the proper and efficient administration of the Medicaid State Plan, **including assisting the individual to establish and maintain Medicaid eligibility**. For example, time spent locating, completing or delivering documents to the Medicaid eligibility worker;

9. Recruitment and outreach activities in which the agency or waiver support coordinator attempts to contact potential recipients of services.

F. Support Coordination reimbursement is available for discharge planning services provided to an NF recipient in the **30-day** period immediately prior to his or her first day of admission to the waiver. This is the only reimbursable waiver service provided to an inpatient of an institution. The NF recipient's Medicaid and waiver eligibility must be documented prior to his or her receipt of waiver-reimbursed services, including support coordinationdischarge planning services.

G. Support Coordination reimbursement may also be available for the time spent by a waiver support coordinator coordinating and conducting an assessment of a **noninstitutionalized** individual's waiver eligibility. However, reimbursement is limited to time spent by the support coordinator: (1) conducting, coordinating, and fully documenting an assessment; and (2) only in the **30-day** period immediately prior to the individual's first day of admission to the waiver. No other waiver services provided during this period are billable to Medicaid. Further, if the individual is found ineligible for the waiver or if the individual is found eligible but for any reason is not admitted to the waiver by the end of the 30-day period (e.g., is placed on waiting list or chooses NF services), the time spent conducting the assessment is not billable as a support coordinatiion service.

H. Time spent by technicians ("support coordination assistants" employed by or under contract with DSPD) who are working under the supervision of a waiver support coordinator may also be billed as support coordination services. **However, technicians may NOT determine level of care nor be primarily responsible for the development or implementation of the plan of care.** Medicaid will reimburse the documented time spent by the technician for activities such as coordination and follow-up with allied agencies and related parties and assisting with the compilation and review of documentation, but only when approved and signed off by the supervising support coordinator.

3 - 2 Homemaker Services

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or herself or others in the home.

3 - 3 Emergency Response System

A personal emergency response system (PERS) is an electronic device which enables recipients at high risk of institutionalization to secure help in the event of an emergency. By providing immediate access to assistance, PERS serves to prevent premature or unnecessary institutionalization of the recipient.

Limitations

PERS services are limited to those recipients who live alone, or live with others who are not able to respond to an emergency, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

3 - 4 Respite Care

Respite care is a service given to recipients unable to care for themselves, provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care may be provided in the following locations:

A. the recipient's home or place of residence;

B. a facility approved by the State which is not a private residence;

C. a licensed group home;

D. a licensed nursing facility; or

E. in the community.

The location of respite care shall be specified in the recipient's plan of care. It may include the private residence of the individual providing respite care, in which case this individual will meet the standards prescribed by the Medicaid-enrolled respite care agency or DSPD Regional Office with whom he or she has a contract. Normally, a maximum of two (and in no case more than four) recipients will be served by the individual at any point in time.

3 - 5 Supported Employment Services

Services which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which individuals without disabilities are employed. Supported employment includes activities needed to sustain paid work by waiver clients, including supervision and training. When supported employment services are provided at a work site in which individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by recipients as a result of their disabilities. Supported employment does not include payment for supervisory activities rendered as a normal part of the business setting.

Transportation may be provided between the recipient's place of residence and the supported employment work site (or work sites when the recipient receives supported employment services in more than one setting) as a component part of supported employment services. Whenever possible, public transportation, or other transportation services without charge will be utilized. When transportation services are provided, reimbursement for the cost will be in addition to the rate paid for the supported employment service.

Limitations

1. Documentation must be maintained in the file of each recipient receiving this service to show that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 97-142 (a Division of Rehabilitation [DRS] form is required to document ineligibility for DRS services prior to delivery of supported employment services); and

2. Federal Financial Participation will not be claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

    a. incentive payments made to an employer of recipients to encourage or subsidize employer's participation in a supported employment program;

    b. payments that are passed through to recipients of supported employment programs; or

    c. payments for vocational training that is not directly related to a recipient's supported employment program.

3 - 6 Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All are subject to Prior Approval in accordance with DSPD policy and must be specified in the plan of care.

Limitations

1. Authorized expenditures for specialized medical equipment and supplies will be based on each recipient's needs. These needs must be documented by an individual who is licensed or otherwise recognized in the State as qualified to make such a determination. Authorized expenditures will be in accordance with DSPD policy.

2. All purchases will comply with State procurement requirements.

3. This service covers durable and non-durable medical equipment (including necessary maintenance and repair) not available under the Medicaid State Plan. Items reimbursed with waiver funds are in addition to and not in lieu of any medical equipment and supplies furnished under the State Plan.

4. This service excludes reimbursement for any items which are not of **direct medical or remedial benefit to the recipient.**

5. All items billed under the waiver must meet applicable standards of manufacture, design, and installation.

3 - 7 Companion Services

Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services.

Limitations

1. The provision of companion services does not entail hands-on medical care.

2. Providers may perform light housekeeping tasks which are incidental to the care and supervision of the client.

3. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

3 - 8 Family Training

Training and counseling services for the families of individuals served on this waiver. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.

Limitations

1. For purposes of this service, "family" is defined as the persons who live with or provide care to a recipient of waiver services, and may include a parent, spouse, children, relatives, foster family, or in-laws.
2. "Family" does not include individuals who are employed to care for the recipient.

3. All family training must be included in the individual's written plan of care.

3 - 9 Structured Day Program

This is a program of meaningful supervised activity directed at the development and maintenance of independence and community living skills. Services may take place at home or in a setting separate from the home in which the recipient lives. Services may include group or individualized life skills training that will prepare the recipient for community reintegration, including, but not limited to, attention skills, task completion, problem solving, safety and money management. The services shall include nutritional supervision, health monitoring, and recreation as appropriate to the individualized plan of care. The service covers transportation to program activities. The program can be individualized using a daily rate, a half-day rate, or an hourly rate as indicated in the plan of care.

Limitations

Vocational rehabilitation services funded by the Division of Vocational Rehabilitation are excluded from payment as a waiver service.

3 - 10 Community Supported Living

Services designed to assist an individual to gain and/or maintain skills to live as independently as possible in a community setting; and based on the outcome for community living indicated in the individual's support plan, live in the type of housing arrangement they choose. The individual's support plan identifies the type, frequency, and amount of support required by the person based on the person's needs and preferences. Support services are available to individuals who live alone, with roommates, or with family.

Community Supported Living also includes direct support services which include assistance with meal preparation, eating, bathing, dressing, and/or personal hygiene. Support services are designed to facilitate independence and promote community integration.

Limitations

1. Community supported living services are necessary to prevent institutionalization.

2. These services do not include the cost of room and board.

3 - 11 Counseling Services

Counseling is a service designed to benefit the waiver client either directly to resolve conflict or issues that may help the individual remain in the community. This counseling will enable the individual to manage his stress and improve the likelihood that the brain-injured individual will continue to be cared for in his own home or the home of his family, thereby preventing premature and otherwise unnecessary institutionalization Services must be included in the plan of care and be for the direct benefit of the client. Services may be delivered in a group or in an individual setting.

3 - 12 Transportation

Service offered in order to enable waiver recipients to gain access to waiver and other community services and resources, required by the plan of care. This service is offered in addition to medical transportation and services offered under the State Plan. Transportation services serve the purpose of allowing the individual access to other waiver supports necessary to live an inclusive community life.

Limitations

1. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

2. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. In no case will family members be reimbursed for the provision of transportation services under the waiver.

4 RECORD KEEPING

A. All individuals and agencies providing Medicaid-reimbursed Home and community-based waiver services must develop and maintain sufficient written documentation to support the services billed.

B. Sufficient written documentation includes the following:

1. the name of the recipient who received the service(s);
2. the specific reimbursable service provided pursuant to the recipient's plan of care;
3. the date the service was rendered;
4. the amount of time spent delivering the service;
5. periodic updates describing the recipient's response to the service (e.g., progress or the lack of progress); and
6. the qualified provider/individual who delivered the service.

C. All records must be maintained by the Medicaid provider and made available as requested for State or Federal audit and review purposes.

5 PROCEDURE CODES

CODE	DHS CODES	DESCRIPTION	UNITS
Y4150	BM	Support coordination	qtr. hr.
Y4151	HSQ	Homemaker Services	qtr. hr.
Y4152	RP1	Respite Care (up to 6 hrs.)	qtr. hr.
Y4153	RP2	Respite Care (up to 6 hrs.)	qtr. hr.
Y4154	RP3	Respite Care (up to 6 hrs.)	qtr. hr.
Y4155	RP3	Respite Care (24-hour)	max
Y4158	SME	Specialized Medical Equipment	monthly
Y4159	SM1	Specialized Medical Equipment	each
Y4160	SM2	Specialized Medical Equipment	each
Y4163	PER	Emergency Response	monthly
Y4164	PER	Emergency Response	each
Y4165	COM	Companion Services	qtr. hr.
Y4166	FS2	Family Training	qtr. hr.
Y4167	FS3	Family Training	qtr. hr.
Y4168	FS4	Family Training	qtr. hr.
Y4169	DTA	Day Training Services	qtr. hr.
Y4170	DTB	Day Training Services	qtr. hr.
Y4171	SEA	Supported Employment	qtr. hr.
Y4172	SEB	Supported Employment	qtr. hr.
Y4173	SED	Supported Employment	daily
Y4174	CSQ	Counseling Services (individual)	qtr. hr.
Y4175	CSQ	Counseling Services (group)	qtr. hr.
Y4179	SLH	Supported Living	qtr. hr.
Y4181	MTP	Transportation Services	daily
Y4182	COM	Companion Services	daily

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